

Personal Training Registration

To be completed by Office Assistant

Client's Name: _____ Phone: _____

Alt.Phone: _____ Email: _____

Age: ____ Sex: M F Trainer Preferred: M F Name: _____

Health History Intake Form Complete: Exercise History/Attitude Questionnaire Complete:

Date received: _____ Payment \$ _____ Receipt# _____ Staff Initials: _____

Check all that apply:

Individual Packages

- 1 Session \$20
- 3 Sessions \$54
- 5 Sessions \$90
- 8 Sessions \$140
- 12 Sessions \$210
- 16 Sessions \$280
- 24 Sessions \$420
- 32 Sessions \$560

Individual Packages Discounted

(Return Clients only-Must have card!)

- 1 Session \$18
- 3 Sessions \$49
- 5 Sessions \$81
- 8 Sessions \$126
- 12 Sessions \$189
- 16 Sessions \$252
- 24 Sessions \$378
- 32 Sessions \$504

Fitness Assessment

- Comprehensive Fitness Assessment \$40
- Comprehensive Fitness Assessment \$35
(With the purchase of a Personal Training Package)

Notes:

To be completed by Supervisor and Personal Trainer

Assigned To: _____ Date Assigned: _____

To be completed by Personal Trainer

Client's stratification:

- Low Risk
- Moderate Risk
- High Risk

Date Started: _____ Date Completed: _____

Notes:

Trainer's Signature: _____

TEXAS TECH UNIVERSITY

Name _____

Phone Number _____

Best time to call _____

****CHECK THE HOURS YOU CAN WORKOUT WITH YOUR TRAINER***

HOURS	MON	TUES	WED	THURS	FRI	SAT	SUN
6:00am							
8:00am							
9:00am							
10:00a							
11:00a							
Noon							
1:00pm							
2:00pm							
3:00pm							
4:00pm							
5:00pm							
6:00pm							
7:00pm							
8:00pm							
9:00pm							
10:00p							
11:00p							

Personal Training Health History & PAR-Q Intake Form

Name _____ Date _____

Local Phone: _____ Alternate Phone: _____ Email
address: _____

Age _____ Sex: Male Female Height _____ ft _____ inches Weight _____ lbs.

Physician's Name _____ Physician's Phone (____) _____

Person to Contact in Case of an Emergency:

Name _____ Date _____ Phone _____

Preparticipation Screening Questionnaire *

Assess your health status by marking all true statements

History

You have had:

- A heart attack
- Heart surgery
- Cardiac catheterization
- Coronary angioplasty (PTCA)
- Pacemaker/implantable cardiac defibrillator
- Heart valve disease
- Heart failure
- Heart transplantation
- Congenital heart disease

Symptoms

- You experience chest discomfort with exertion.
- You experience unreasonable breathlessness.
- You experience dizziness, fainting, or blackouts.
- You take heart medications.

If you marked any of these statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You will have to obtain written medical clearance from your physician and may need to use a facility with a **medically qualified staff**.

Other Health Issues:

- You have diabetes.
 - You have asthma or other lung disease.
 - You have burning or cramping sensation in your lower legs when walking short distances.
 - You have musculoskeletal problems that limit your physical activity.
 - You have concerns about the safety of exercise.
 - You take prescription medication(s).
 - Please list all medications: _____
 - You are pregnant.
-

Cardiovascular risk factors

- You are a man older than 45 years.
- You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal.
- You smoke, or quit smoking within the previous 6 months.
- Your blood pressure is > 140/90 mm Hg.
- You do not know your blood pressure.
- You take blood pressure medication.
- Your blood cholesterol level is >200 mg/dL.
- You do not know your cholesterol level.
- You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister).
- You are physically inactive (i.e., you get <30 minutes of physical activity on at least 3 days/week).
- You are >20 pound overweight.

If you marked two or more statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You may have to obtain written medical clearance from your physician and you might benefit from using a facility with a **professionally qualified exercise** staff to guide your exercise program.

-
- None of the above

You should be able to exercise safely without consulting your physician or other appropriate health care provider in a self-guided program or almost any facility that meets your exercise program needs.

Please note: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan. Texas Tech’s Department of Recreational Sports and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, please consult your doctor prior to physical activity.

“I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.”

Name _____

Signature _____

Signature of Parent _____

(for participants under the age the majority)

Date _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the questions.

Exercise History and Attitude Questionnaire

Name: _____ Date: _____

General Instructions: Please fill out this form as completely as possible. If you have any questions, please ask your trainer for assistance.

1. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value and 5 indicating the highest). Circle the number that BEST applies.

a) Characterize your present athletic ability.

1 2 3 4 5

b) When you exercise, how important is competition?

1 2 3 4 5

c) Characterize your present cardiovascular capacity.

1 2 3 4 5

d) Characterize your present muscular capacity.

1 2 3 4 5

e) Characterize your present flexibility capacity.

1 2 3 4 5

2. Were you a high school and/or college athlete? YES NO

a. If yes, please specify: _____

3. Do you have any negative feelings toward, or have you had any bad experience with, fitness testing and evaluation? YES NO

a. If yes, please explain: _____

4. Do you start exercise programs but then find yourself unable to stick with them?

YES NO

5. How much are you willing to devote to an exercise program? _____ minutes/day _____ days/week

6. What types of exercises interest you?

a. <input type="checkbox"/> Walking	<input type="checkbox"/> Jogging	<input type="checkbox"/> Swimming
b. <input type="checkbox"/> Cycling	<input type="checkbox"/> Dance exercise	<input type="checkbox"/> Strength training
c. <input type="checkbox"/> Stationary biking	<input type="checkbox"/> Rowing	<input type="checkbox"/> Racquetball
d. <input type="checkbox"/> Tennis	<input type="checkbox"/> Group exercise	<input type="checkbox"/> Stretching

7. Are you currently involved in regular endurance (cardiovascular) exercise?

- a. YES NO

If yes, what type of exercise(s) _____ minutes/day
_____ days/week

8. Rate your perception of the exertion of your exercise program (circle the number):

- (1) Light (2) Fairly light (3) Somewhat hard (4) Hard

9. How long have you been exercising regularly? _____ months _____ years

10. What other exercise, sport, or recreational activities have you participated in?

a. In the past 6 months? _____

b. In the past 5 years? _____

11. Can you exercise during your work day?

- Yes No

Goal Setting

Goal setting is a major aspect to training. It is important that you set the right goals for yourself. Together you and your trainer will you set the goals that are appropriate for you in order to assure that you get the most out of each session. When choosing goals they should be **S.M.A.R.T.**

Specific-If your goal is weight loss; try to make it more specific. Try stating the amount of weight, the time frame, and the method of measurement (scale or body fat %).

Measurable- To truly evaluate improvements, the goal should be measurable. The way you look is not tangible, reliable measurable.

Attainable- Goals should be challenging but possible. Keep in mind how long you are allowing for reaching your goal and make sure that is safe and realistic.

Relevant- Goals should be pertinent to your interest, needs, and abilities.

Time bound- Set a timeline reaching your goal. Again be realistic.

12. Please rate your exercise goals using the following scale:

Extremely Important				Somewhat Important				Not at all Important	
1	2	3	4	5	6	7	8	9	10

- a. Improve cardiovascular fitness _____
- b. Body-fat weight loss _____
- c. Reshape or tone my body _____
- d. Improve performance for a specific sport _____
- e. Improve moods and ability to cope with stress _____
- f. Improve flexibility _____
- g. Increase strength _____
- h. Increase energy level _____
- i. Enjoyment _____
- j. Other _____

15. Is there any specific goal(s) you'd like to work towards? _____